Subcommittee #2, EHR in Private Medical Practice Meeting Minutes

Department of Medical Assistance Services (DMAS)
600 East Broad Street
Richmond, VA 23219
9th-floor Conference Room, 2:00 – 3:30PM
September 19, 2005

Attendees:
Members:
John Dreyzehner, MD (Substitute Chair)
Doug Gray
Carol Pugh
Guest Speakers:
Chip Childress from HMG
Sandy O'Dell from Frontier Health (for Doug Varney)
Staff:
Dave Austin
John Kenyon
Liza Steele

AGENDA ITEMS

I. Review of 8/29/2005 Teleconference Minutes

The Subcommittee approved the August 29, 2005 minutes.

II. Case Studies in the Development of EHR in Medical Practices

A. Chip Childress, Director of IS Holston Medical Group (2:15PM)

Attributes of Holston Medical Group:
Multi-specialty physician practice, privately owned. They have104 providers across 14 locations across NW TN and SW VA. The Holston Medical Group (HMG) serves 200,000 patients. There are up to 40,000 patient visits per month in. 3 locations in SW VA. There are 12 providers located in VA. This group is using its second EMR product now. Converted to it about 6 years ago. Using several modules: results module, lab, radiology, immunizations, medications, workflow engine, problems, and document imaging. They started with their first basic EMR product 10 years ago. They feared that the original vendor wasn't interested in staying in that market, so they switched away from using their product. They switched to All-Scripts Touch Works. They felt like EMR technology was a "horse race" and that there was no clear leader in the market. They wanted to deal with a company that had an EMR product as their core product.

Their EMR Incentives:
Their motivations for using EMR were so that they could:

- Not depend on insurance company data; and
- Be a leader in the market from a technological standpoint.

IT Staffing:
Company wide HMG has 8 people in IT and 20 people in their document-imaging department. The document-imaging people scan everything that doesn't come in electronically. Recently they began accepting electronic faxes, which helps.

Buy-in and Implementation:
With 104 providers, they have the entire gamut of people – those who like the technology, and those who don't. They try to think in terms of their average user; that is the user frame of reference they use. They have 14 locations, so they did each implementation on its own. This is also partly because of the differences among personalities across the offices, etc. In terms of the time it takes to do the implementation, they have found that with two weeks of a half–schedule, they can be full functioning in a month. They have trainers on site so that their physicians can get a quick response when they have a question or issue. This "tends to be the most critical part," he says. He reiterated that the thing to do is to gear things towards the average user and not focus so much on what is at either end of the range. He said the product they have now has really become part of their culture.

When asked how "out of the box" the All-Scripts software is, he said it's "definitely do-able". He mentioned that things have changed a lot since they started, and that he wouldn't call it a "Microsoft-Office-and-go" type of thing, but that it has gotten easier than it used to be.

ROI:
HMG is saving $10-12K per month on transcription costs. (This is also in part because they were at 14 lines per encounter and have reduced that to 5 lines per encounter in the last couple of years.) "Generic drug utilization" has also gone up, since their EMR system can automatically flip a brand name to the generic. Two years ago they were at 42% generic utilization; they are now at 67%. They have been able to recoup some money because of this. Also, they can do clinical research, which is good for patients because they get free medications. They can pre-qualify a good group of patients for a study, since they have 10 years of data. This translates into a revenue source. Also, faxing or electronically transmitting prescriptions have made prescription filling more efficient.

Final Comments:

- They can negotiate better contracts with payers because of EMR efficiencies.
- They do not have any emergency room interaction in connection with their EMR software but plan to partner with the Care Spark RHIO to create the interface.

B. Sandy O'Dell (for Doug Varney) for Frontier Health

Frontier Health's Background:
Her company has a contract with Community services Board. They deal with behavioral health issues where she works and are a private, not-for-profit company that represents the merger of several behavioral health organizations that occurred back in 1997. Frontier Health had over 80 facilities, including a psychiatric facility with 75 beds and 1,100 staff. They had a lot of facilities across a large service area, so they started putting together an EHR committee trying to flesh out an electronic health record. Their priority was establishing a clinical behavioral health record in all of their outpatient centers. Frontier made an investment in almost 800 PCs a few years ago. Deployed those so that all facilities could operate with the same hardware. She indicated that it was a huge hardware investment, not including the IT personnel.

Today they have a fully integrated mental health record – currently they are working on the one for mental retardation.

They had a large number of motivating factors – reduction of transcription costs, communicating across VA and TN, better use of clinical and administrative time, communicating with state facilities and training centers, communicating with medical providers in the community, among others – when they got into EMR.

Buy-in and Usage:
She said the older folks had a harder time with the buy-in. They are using voice recognition with nurse practitioners and physicians. They are using the Electronic Prescription-writer tool. Most notes are completed using the voice recognition, which allowed them to reduce transcription costs and staff. They have been up and running with Prescription-writer for 6 months.

The Use of Pilot Sites:
They used one VA site and one TN site for pilot sites. They rolled out anything new to those sites first. They did this to work out bugs before rolling everything out to the other 18 clinical sites. She said this process was smart and worked well for them. She said they felt it was critical to work out the bugs, thus frustrating the minimal number of clinicians. Their

groups of clinicians and IT folks had to function as a cohesive team to make the whole thing work.

Miscellaneous:

- Initial capital outlay is difficult for not-for-profit organizations like theirs
- Planning District I Behavioral Health Services is the only one that contracts for all of their services

III. Potential Pilot Program Discussion From the Floor

There were no new proposals.

IV. Subcommittee #2 Draft Report (Version 2) to the Full Task Force

A. Discussion/changes/additions/deletions

Dave opened up the discussion by asking for input. John Dreyzehner mentioned that the real meat of the document is in the first 20 pages. It was asked if the attachments would be excerpted. Dave said they might be placed at a URL or might be referenced somewhere with where you could find all the details, or that they might in fact be excerpted.

Greg Walton's comments (by e-mail:
Page 5, in reference to Roles of the Commonwealth he agrees with all points except two. "Sponsor electronic prescribing tool for use by high volume Medicaid Providers and plans, tied to state formulary/PDL." Also, "Develop and implement electronic health and medical record tools for high-need populations". First, I disagree that the State should "sponsor", which I believe means fund. Second, buying a prescribing tool would be a mistake because it is a single function tool. An EMR deals not just with ordering pharmacy, but all kinds of orders, problems, results, documentation, etc. I could support finding for an EMR.
Second, I do not understand what the "Develop and implement electronic health and medical record tool for high-need populations" means. …This just seems unclear.

John Dreyzehner's comments:
He said he had an issue with the phrase, "…appear in priority order" in reference to the State roles listed on Page 4. Dave asked if there was consensus on this. The answer was yes. He also said bullet point number 3 under Payer is ambiguous and warrants clarification. Clarification was made in reference to specific population (high need populations, disparity populations, and chronic-disease). Dave asked what he thought of the first two bullets (e.g., including incentives to offset costs for providers) under

"Payer" role. It was suggested that that was OK and that incentives might be best in poorer areas.

The issue of providing incentives was discussed at some length. Dave said we would work on bullet number two and drop bullet number one, in addition to editing bullet number three (under Payer, again).

No comments on state's role as purchaser. It was suggested that EHR should replace EMR throughout the document.

V. Upcoming Items

A. Governor's Task Force Meeting 10/3/2005

B. Miscellaneous Items - None